Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002407	A. BUILDING: _____ B. WING _____	04/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL HEALTH CARE PROFESSIONALS INC	525-B W BRISTOL ST PO BOX 147 ELKHART, IN 46515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a home health state relicensure survey. Survey dates: 4/15/13 - 4/17/13 Facility: #002407 Surveyor: Tonya Tucker, RN, PHNS Census: 28 Skilled: 8 Aide only: 0 Personal service only: 20 Home visits: 2 Regional Health Care Professionals Inc is in compliance with the Indiana rules for licensure 410 IAC, Article 17. Quality Review: Joyce Elder, MSN, BSN, RN April 18, 2013	N 000		